GEORGIA DEPARTMENT OF COMMUNITY HEALTH

MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM - CRITICAL ACCESS HOSPITAL PROGRAM

Application for Hospitals Seeking Designation as a Critical Access Hospital

I Description and Ownership Status:

A. Hospital name and address:

Hospital Name: _____

Street: _____

City/St/Zip: _____

County: _____

B. Please provide sufficient proof of non-profit or public ownership. Provide documentation as **(Attachment A)**

C. Please provide a complete description of the facility. (Construction type, layout, year built, etc.)

D. Number of Licensed Beds:

E. Services currently provided:

F. Average daily census by service:

_____ Medical Inpatient	_____ Swing Bed	_____
_____ Outpatient Surgery	_____ Newborn	_____
_____ Lab Outpatient	_____ Obstetrical	_____
_____ Emergency Department	_____ Intensive Care	_____
_____ Physical Therapy	_____ CCU	_____
_____ x-ray Outpatient	_____	_____
_____ Respiratory Therapy O/P	_____	_____
_____ Observation Patients	_____	_____

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Description continued:

G. Average Length of Stay: Medicare: _____ (hours) Medicaid: _____ (hours) Private Pay: _____ (hours) State Merit _____ (hours)

H. Inpatient Utilization: Medicare: _____ % Medicaid: _____ % Private Pay: _____ % State Merit _____ %

I. Outpatient Utilization: Medicare: _____ % Medicaid: _____ % Private Pay: _____ % State Merit _____ %

II Financial Analysis

A. Comparative analysis of hospital reimbursement for the most recent cost report year under Medicare PPS reimbursement and the proposed CAH cost-based reimbursement. Technical assistance is available for this. Please phone Charles Owens by calling 229-401-3092 for information on a state funded comprehensive financial analy Please provide a copy of the analysis as **(Attachment B)**.
B. Please provide audited financial statements and notes for the three most recently completed years as **(Attachment C)**.
C. Please provide a three year projection of reimbursement as a CAH, showing financial feasibility to sustain the hospital as **(Attachment D)**.

III. Community Needs Assessment:

A comprehensive community needs assessment must be conducted involving a variety of local stakeholders including for example but not limited to: community and business leaders, county commissioners, city manager, health professionals, residents, et. al
Please ensure that as a MINIMUM, the assessment includes:

A. A description of the community including county area demographics, health status (including prevalent diseases and environmental impact), the impact of managed care on the community, local economic trends and a listing of all health care resources and an assessment of the strengths and weaknesses of the community's present health care system.
B. A description of prioritized critical health care needs which are impacting the delivery of healthcare services.
C. Results of the assessment of the availability and utilization of health care services in the community, including acute inpatient care, outpatient care, primary care and emergency medical services:
D. A description of the community needs assessment and decision making process, including delineation of the process used for data collection, community education and involvement, prioritizing community needs and dissemination of the results to the community.
E. A description of the integration of services and collaboration with adjacent facilities to provide a wide array of services to meet the needs of the community.
Please attach the community needs assessment as **(Attachment E)**.

IV. Health Care Delivery Plan

The health care delivery plan should detail how the health needs identified in the community needs assessment are to be addressed by the hospital. Please ensure that as a MINIMUM, the health care delivery plan includes:

A. Strategies for meeting community needs and how they will be accomplished including identifying potential partnerships and cooperative relationships.
B. A timeline for implementation of the health care delivery plan.

Please attach the health care delivery plan as **(Attachment F)**.

V. Evidence of Participation in a Network:

A. Please provide below a pictorial (diagram) of your health care network including all referral hospitals and partners.

B. Please detail the **role** of each network member in the above diagram. List the complete address with the name and phone number for the responsible contact person at each facility.

Please note that if the "Model Agreement" provided by the State is used, it will serve as attachments G through L.

C. Signed agreements:

1. Patient Referral and Transfer.
   Due to the length of stay limitation at the CAH, emergency and or non-emergency transport may be required when a patient's condition deteriorates, or it is determined that the patient is in need of a longer length of stay or requires services which are not available at the CAH. The transport agreement with the network referral hospital should include the availability of reliable and timely transport. (Please provide as **Attachment G**).
2. An agreement between the Critical Access Hospital and its referral hospital(s) shall require an assessment of the emergency stabilizing skills of emergency room personnel at the CAH along with the availability of surgical services and ancillary services (lab, radiology) available at the CAH. Please attach documentation as **(Attachment H).**
3. Agreement with network referral hospital for the development and use of a Communications System of the Network including (if your hospital has systems in place) for telemetry and electronic sharing of data. **(Attachment I**).
4. Provision of Emergency and Non-Emergency Transport. Plans shall be established in concert with the emergency medical system for appropriate transportation of patients with identified emergency medical conditions to ensure that patients get to the right place at the right time and with the right care provider. (Provide as **Attachment J**)
5. Agreement with network hospital for on-going quality assurance evaluations of how well the CAH hospital is performing relative to the provision of care (including emergency medical care) and provide assurances that effective corrective actions will be taken for identified problems. (Please provide at **Attachment K**).
6. Each critical access hospital shall have an agreement with respect to medical staff credentialing with at least one hospital that is a member of the network or other appropriate and qualified agency. **(Attachment L).**

D. Emergency medical conditions (if any) that are most likely to need the skills/procedures/services that the CAH can not provide and would likely be transferred shall be identified. (Please provide as **Attachment M**).

E. Please describe below the data collection and reporting capabilities for each network member (including your hospital). (Eventually we would like to have an electronic network in place to connect all network partners. We need to know your current capacity to share data electronically.)

VI. Hospital Emergency Services:

Hospitals applying for Critical Access Hospital Designation that elect the option of temporarily closing their emergency room must provide assurances of intent to meet all state requirements as listed below.

Please note: ALL HOSPITALS MUST PROVIDE ATTACHMENT **N** AND **O and P**

1 The emergency medical system shall be informed at all times regarding the temporary closing of an emergency room. Please provide as **Attachment N** your hospitals agreement with the local emergency medical system.

2 A physician must be on call 24/7 and available IMMEDIATELY by PHONE or RADIO to hospital and local emergency medical system personnel for emergency patient care direction. Please provide as **Attachment O** your hospital's plan for physician availability in emergency situations.

3 On-Call Emergency room staff shall be available to the emergency medical system via beeper when the emergency room is closed. They must be able to report to the emergency room within 30 minutes of notification. Please provide as **Attachment P** your hospital's plan for emergency room personnel availability in emergency situations.

4 Prior to the effective date for the transition to a CAH, the hospital must announce in newspapers and on the radio in the geographic areas served, the possible closing of the emergency room. Please provide as **Attachment Q** your hospital's plan to carry out this requirement.

VII. Medicare Conditions of Participation as a Critical Access Hospital

There are 13 Medicare conditions of participation for the Critical Access Hospital Program. Please refer to the attached copy of the conditions with survey guidelines and procedures. This is the information you will need to prepare for the compliance survey by the Office of Regulatory Services. For this application you must provide written assurance to the State of Georgia that your hospital will comply with these conditions of participation. Each condition must be individually addressed. For each condition you must show how your hospital can meet or exceed the requirements of the condition. A compliance survey by the Office of Regulatory Services will be scheduled after your application has been reviewed by the Health Care Financing Administration.
Please provide as **attachment R**, assurances of your hospital's ability to meet or exceed each of the 13 conditions of participation as well as the special requirements for CAH providers of long-term care services (swing-bed) if your hospital provides this service.

VIII. Letters of Support

Please provide as **attachment S**, letters of support from hospital stakeholders (ex: hospital medical staff, county medical society, et.al.)

IX Signature Block

The information provided in this application is to the best of my knowledge true and accurate and completed

this _____ day of _____, 2002.

_____
Administrator/CEO

_____
Hospital Name

Concur:

_____
Chair, County Commission

_____
Chair, Hospital Authority